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Anniversary Program—150th Year U. S. Public Health Service

The Past and Future of the Public Health Service *

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THIS morning, 17,000 men and women of the Public Health Service turn their thoughts to this platform. From 44 of the 48 states, from Alaska, the Canal Zone, Hawaii, Puerto Rico, and the Virgin Islands, from headquarters in Washington, and from 14 foreign countries, we salute the American Public Health Association. And we say: "Thank you for honoring us in this special program to commemorate the 150th anniversary of the Public Health Service."

All of us feel that the Health Officers Section has provided an unusually fitting climax to our sesquicentennial. No professional society, no voluntary agency, is so closely related to the Public Health Service as the American Public Health Association. The two organizations are indeed blood relations, for each has fed the life-stream of the other since 1872 when the Association was organized with an officer of the Marine Hospital Service among its ten founders. Eight Presidents of the Association have been Public Health Service officers at the time they held office. Several others have been Service officers at some time in their careers.

As this memorable year draws to a close, then, the Public Health Service feels a special pride in being able to come before the Association with our storied past and our renewed faith in the future.

Coincidence places this commemorative meeting in a perfect setting. Boston is both the cradle of the Public Health Service and the birthplace of the modern public health movement in the United States. Here, in 1799, the first U. S. Marine Hospital opened its doors to sick and injured seamen. Here, too, in 1845, and again in 1850, Lemuel Shattuck wrote his classic reports which became the blueprint for American health organization.

The origins, growth, and development of the Public Health Service are well known, in broad outline, to most of this audience. This is fortunate, because a little mental arithmetic tells me that the time at my disposal allows about 40

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seconds for each decade of our 150 years, and a few minutes for a look at the limitless future. Such a superficial account would not be satisfying either to the speaker or the audience, so I shall proceed quickly to the future.

First, let us look at our organization as it is today. Our financial situation—I will say this with Yankee caution—is "tol'able." In 1948, appropriations to the Public Health Service, including contract authorizations for construction, totalled over $200 million, and for this fiscal year, 1949, over $275 million. We have three new programs which are not covered by the 1949 budget: the National Heart Institute, the Dental Research Institute, and the program for water pollution control. We await the meeting of the new Congress for full activation of these programs. So I say our situation is "tol'able." Our 1948 and 1949 budgets, however, represent increases upward of 2,000 per cent over appropriations available 15 years ago.

In 1917, the Public Health Service had only 187 commissioned officers, all physicians, and less than 2,000 other employees. In 1940, the combined force included about 8,500 persons. Today, the total, full-time staff of the Service numbers 17,000, of whom 2,000 are officers in the regular and active reserve corps, now including physicians, dentists, engineers, sanitarians, pharmacists, nurses, and dieticians.

The programs of the Service are in three major categories: research, clinical medicine, and public health administration. Three major administrative units complement those categories: the National Institutes of Health, the Bureau of Medical Services, and the Bureau of State Services. The Office of the Surgeon General is presently a fourth bureau, composed of a few unrelated divisions and of the internal management services, such as budget and fiscal, personnel administration, and supply procurement.

Here is a point at which we can take a look at the future. One of my first concerns as Surgeon General is to improve the efficiency of the Public Health Service. The expanding magnitude of our responsibilities demands it.

Six months ago, I appointed a Committee on Organization, composed of members of my staff,* to make a comprehensive study of the organizational structure and working relationships of the Public Health Service, at headquarters and in the field. The committee, under the chairmanship of Deputy Surgeon General W. Palmer Dearing, has worked throughout the summer with the help of many other members of the Service in the various bureaus. They have come up with a series of initial reports which I regard as statesmanlike—reports dealing with general principles of organization and with the committee's first area of inquiry—federal-state activities.

COÖRDINATION OF SERVICES

It is too early to report here the outcome of the committee's specific recommendations. But I can tell you that already the Public Health Service is moving *away* from a categorical approach in all of its activities, and *toward* a more generalized and unified approach.

That trend will be accelerated in the immediate future, and its scope will be broadened. In research, clinical practice, and public health administration, we cannot—and do not—deny the vital importance of specialization. But we do—and we must—abhor the isolation of special knowledge, skills, and services in water-tight compartments.

The end result of isolation can only

* Public Health Service Committee on Organization: W. Palmer Dearing, Deputy Surgeon General, Chairman; Harry G. Hanson, Executive Officer, Secretary; J. W. Mountin, Assistant Surgeon General, Bureau of State Services; Mark D. Hollis, Assistant Surgeon General, Sanitary Engineering; R. W. Bunch, Administrative Officer, Bureau of Medical Services; A. F. Siepert, Executive Officer, National Institutes of Health.

be stultifying, whether it occurs horizontally across the three major types of activity, or vertically through the scientific disciplines, the medical specialties, or the categorical health programs. The scope and depth of human knowledge, the infinite variety of special technics are such that no one mind, nor group of minds, can encompass them.

But recognition of this fundamental truth is not enough. It is easy to philosophize and say that all the disciplines and services related to the health of mankind are interdependent. Somewhere, sometime, a start must be made toward an interdisciplinary, integrated approach in all agencies responsible to society for the study and health care of the people.

The Public Health Service, then, is putting its house in order so that we may use fully and more effectively the increased resources provided by Congress for the health of the people. Needless to say, we shall act within the framework defined by the Congress; but we shall seek legislation to authorize any basic changes which we believe to be necessary for efficient administration.

This does not mean a lessened interest in the pioneer work that must be done against the major health problems of our times. Quite the reverse; our plans are to strengthen and sharpen the attack already begun against such massive problems as heart disease, cancer, and mental disease. Other specific problems of the times also await attention. Our interest is in perfecting the Public Health Service administrative machinery through which the objectives of all our programs are reached.

Simply, what we are aiming toward, is to make of our large, sprawling organization a hard-driving, united team. The Public Health Service has grown, programs and separate units have multiplied so rapidly in the past 10 years that there has not been time to prevent a somewhat unbalanced development.

We believe that the collaborating team is the best instrument for the pursuit of knowledge and the provision of health services. Because this is our belief and because we hope to see it adopted throughout the whole structure of research, clinical practice, and public health administration in the United States, we must, perforce, heed those simple words of advice: "Physician, heal thyself." This we propose to do.

LOCAL HEALTH SERVICES

There is one motivating force behind the plans and hopes of the Public Health Service which transcends all special interests. It is a dream that dawned in the minds and hearts of public health workers about 40 years ago. That dream: a local health unit for every community in the United States.

There are men in this audience (some of them members of the Public Health Service) who have fought for that dream all those years, or throughout their professional lifetime. Many men have died without seeing this, their dream, come true. The vision and faith of these men have fertilized the entire field of organized health work for nearly two generations.

"Public health is indivisible," they have said. When the Social Security Act was passed in 1935, providing specifically for the development of local health services—but not for particular disease categories—those men thought the battle was at least half won. The Public Health Service, with its colleagues from the states and territories, supported these principles: Grants-in-aid should be general; the budget structure should be simple; there should be reasonable latitude for administrative discretion in the use of funds appropriated for public health work.

Since that time, the proponents of a generalized health program and full-time local health service have been

somewhat like the salmon—swimming upstream against the strong current of categorical appropriations and programs. They have kept on swimming. The goal is nearer, but it is still far off. That is to say, less than 5 per cent of the American people have fully staffed, well qualified, well supported health services. Although the goal is far from accomplishment, it must not remain far off in time.

Within the next year, an effective plan for insuring complete coverage with local health units must be put into operation. I am convinced that unless definite action is taken by state and local governments to increase organized health services to the people, we shall not be able to advance against the major causes of death and disability in the United States.

Public health work, indeed, seems to have arrived at the still center of human need. If it does not now adapt to contemporary needs, the hurricane of needless death and disease will sweep off in new directions, unchecked by the preventive methods which dynamic, coordinated health services could apply.

We already have evidence that the categorical programs themselves are still far from attaining their objectives, despite the money and effort devoted to them. The reason seems clear. In too many parts of the country, there is no qualified organization to bring the new, special services continuously and effectively, to the people. Even where all the health programs are unified administratively in the local health department, budgetary complications and conflicting lines of authority frequently hamper economical use of funds. These restrictions are even more seriously reflected in the quality of the service rendered to the public.

Additional legislation will be required to insure adequate federal support for local health units. There is a ceiling on Public Health Service appropriations for general grants-in-aid to the states. There are no cealings on such specialized programs as tuberculosis, venereal disease, and cancer control. But it may be that Congress, in the future, will take as a criterion for both general and special grants, the extent to which the states have organized and supported local health units in their jurisdiction.

The Congress and the federal agencies may well say to the states and communities: "It is your move." State aid to local jurisdictions falls far short of the needs. Many communities, on the other hand, do not take advantage of state laws and state aid already at their disposal. State aid to communities should be on the same basis on which federal aid is given to the states —that is, high quality consultative and technical assistance, liberal grants with wide administrative latitude for the local jurisdiction, and requirements for local participation, however small.

The Public Health Service will continue to demonstrate and stimulate expanded health services. We will request that the ceiling on grants for general health programs be removed. And we will support legislation for local health units if it is introduced in the next Congress, and if such action is in accord with the President's policy. In this entire effort, we have the full support of the Federal Security Administrator and our colleagues in the agency.

Last spring, I appeared before a Congressional committee in support of a bill for aid to local health units. Among the few civic organizations supporting the bill, the National Congress of Parents and Teachers bore the brunt of the battle. The State and Territorial Health Officers Association, the American Public Health Association, and the American Medical Association strongly endorsed the bill. Unfortunately, it could not compete successfully with other legislation. We can only

hope that the American people will demand passage of such a bill if one is introduced again, as surely it must be.

There is, indeed, no lack of moral support for full development of local health services. The organizations I have mentioned have been joined by other strong civic groups, such as the Farm Federation and the General Federation of Women's Clubs. More recently, some of the voluntary health agencies have begun to see the importance of the local health unit to their own programs.

Federal legislation, however, is not the only requirement for nation-wide local health services. State and local governments must take more responsibility. They must support the recommendations of their central health agencies for well planned, state-wide development of local units. State and local action, in fact, must be the spark plug for increased federal support.

All organizations must work with the public at state and local levels to get the comprehensive health services the people need. The federal government can only bear its share of the responsibility for leadership and help. The needs arise in the communities and the states. So must action arise in the communities and the states.

I suspect that the health officials, the professional and civic leaders, need to recapture some of the missionary spirit which 40 years ago inspired the pioneers. We, in the Public Health Service, have inherited that spirit from such rugged pioneers as Lumsden, Frost, Carter, and others. Many of us were trained by those men. We are still somewhat baffled to find that it is harder to "sell" legislative bodies on the idea of the local health unit than on attacking a particular disease. Some say that the local health unit lacks drama. No man who walked down the country roads with Lumsden 30 years ago would agree.

When Lumsden began his rural health campaign in 1914, our self-confessed "Shoe-leather Epidemiologist" sent his boys from house to house preaching the gospel of the sanitary privy. But his aim was what is now the Number 1 goal of public health: the modern, model, all-purpose local health unit. A unit adequately staffed with well trained physicians, public health nurses, health educators, sanitarians, technicians, and other needed specialists. A unit housed in a functional, good-looking building—the health center. A service, conveniently available to all citizens; working jointly (even under the same roof) with the local hospital and private physicians.

Lumsden's methods were as direct as his plan was far-reaching. You went into a county where the death rates were high and the flies thick. You went from house to house and explained to the families that typhoid, hookworm, and the "summer complaint" which killed their babies, came from their dilapidated backhouses. You showed them how and why a nice, fly-proof, sanitary privy would help protect their health. You persuaded them to rebuild. (Later, you went back—or Lumsden would want to know why you had not—to see whether they had done anything about it.) You gave lectures on sanitation—in churches and one-room school houses. You rounded up prominent citizens, and gave them an extra earful.

By the time you had finished this softening-up process, they were glad to invite you to survey their community and tell them what to do. Probably you already knew what should be done. But you made that survey with the same attention to detail, the same curiosity (for you might run across something unusual anytime), the same zest that filled you the day you decided to go into the Public Health Service.

The purpose? "The ultimate purpose," Lumsden wrote in 1916, "is to awaken in rural communities an indi-

vidual and communal interest in public health questions, which in turn will lead to an improvement in sanitary conditions and *the maintenance of an official local health agency.*" To this day, Lumsden's boys fondly recall that this purpose is what puts "the foolish glimmer in your eyes."

The Public Health Service could give little help for attaining that vision until 1936. For a few years after World War I, the Public Health Service had as much as *half a million dollars* to help interested states in developing local health work. But by 1928, the recession of public health work was on its way to the bottom. The Service that year had only $350,000 to spread among 204 counties in 17 states.

In that year, one of my distinguished predecessors, Dr. Hugh S. Cumming, revealed in a single sentence, the discouragement of health agencies throughout the country. "At the present rate of progress," the Surgeon General wrote, "about *fifty-one* years will be required before all the rural communities in the United States will be receiving adequate health service, the lack of which is responsible for an annual economic loss of one billion dollars."

Twenty of those 51 years are gone. This year, the Public Health Service dedicates itself to cutting that predicted time lag by at least 25 years. We must attain complete coverage of the country in the next 5 years. It would be ironical indeed if the richest nation in the world should take longer than a generation to complete a task so well begun, and so vital to the well-being of its people.

COMPREHENSIVE, MAXIMUM SERVICES

The public health agencies and professions need to take a broader view of the services required in our communities. What would have been the outcome if, say 10 or 20 years ago, the official health agencies and professional societies had broadened their concept of a local health unit's functions? That question perhaps can never be answered. But it may not be far from an accurate surmise that the current imbalance in many public health programs is a direct result of the "minimum service" point of view.

The need for the so-called "basic services" cannot be denied. But they are not enough, and they have never been enough. As nature abhors a vacuum, the voluntary agencies rose naturally. They rose from the American people and the American drive to get things done, to fill vacuums left by traditional and inadequate public health programs.

May there always be voluntary agencies to spearhead needed action! May there never come a time when only official agencies are active for the people's health! No thoughtful health officer can overlook the significance of these popular movements, devoted to the cause of particular population groups or to the conquest of a particular disease. In each instance, the public health programs had failed to give that problem the attention it deserved. Voluntary effort must always be welcomed and fostered in our country.

In this Atomic Age, full preservation of our man power is vital to the very existence of democracy in the world. Neither state, local, or federal governments, nor voluntary agencies, nor professional organizations, nor the people themselves, can afford to shirk their full responsibility to work together for higher levels of health.

I spoke earlier of the present interest of the Public Health Service in simplifying the administration of grants-in-aid to the states. It must be clearly understood that our ability to do so will depend on evidence in the state plans that the states accept their responsibility to carry forward the attack on inadequate health services of all types.

We expect the special programs, stimulated by federal support, to be pressed with greater vigor.

Moreover, there are many fields, clearly within the province of public health work, in which the states should pioneer without the stimulus of "categorical" appropriations by Congress. Housing, for example, holds first rank in social problems of today. Despite the distinguished studies made by the American Public Health Association under Dr. Winslow's direction, healthful housing has had almost no attention by official health agencies.

The relation of housing to the spread of communicable diseases is too well known to merit discussion here. The amazing point is that the problem is so well known, and that so little is done about it. The effects of poor housing on mental health can only be surmised; but we cannot ignore, as indices, the rising rates of juvenile delinquency, divorce, and violent death in familial situations. Home accidents, too, rank high as a cause of death and disability. Public health agencies, it seems to me, can no longer ignore the problem of housing.

The Public Health Service began a few weeks ago to assume its responsibility in this field. Our engineers are working with the various federal agencies concerned with housing to define the areas of health interest in the total problem. We expect them to come up with recommendations for public health action. The state health agencies also should give more attention to the housing problem in their jurisdiction. The United States can no longer afford to tolerate, for example, the woeful conditions in many of the "fringe areas" beyond the corporate limits of our populous cities, often beyond the protection of municipal sanitary and construction codes.

I mention housing as an example of problems which exist or may arise, and which should be given attention in current public health programs. There are, of course, many other important services, partially developed or neglected. My purpose is to stretch the minds of public health workers to a realization that theirs is a dynamic job; that they never can be satisfied with what *has* been done, or even with what *is* being done. Our satisfaction can be only in keeping a perpetual vigil over the needs of the people we serve, alert to new problems and new methods.

The local health unit is an ideal instrument only so long as it is flexible; ready to take the leadership in introducing new programs; ready to follow the lead of the community it serves, demonstrating the peculiar genius of the American people to accomplish their social aims by the coöperation of governmental and voluntary agencies.

TRAINING OF PUBLIC HEALTH PERSONNEL

The ideal local health unit will remain a dream so long as the men and women who serve in it lack the training they need. Estimates made by the National Health Assembly last May show that training is needed for at least 60,000 persons in order to provide minimum staffs for nation-wide health units.

The concept of formal training for public health work took shape only 30 years ago, when the first graduate school of public health was established. Others followed rapidly, but even today there are only 9 accredited schools of public health in the United States. A new one, as most of you know, is being developed in the University of Pittsburgh by former Surgeon General Thomas Parran.

During the past 3 years, the Public Health Service has developed a comprehensive program for inservice training of its own professional personnel in research, clinical, and public health

branches. Likewise, we have been able to help the professional schools to expand their research and training programs in the special fields of cancer and psychiatry. Under the new programs for dental research and heart research, we shall be able to give similar assistance in these special fields. As yet, however, we have been unable to give general assistance to the professional schools.

The Public Health Service proposes to expand its training program for its own employees to the limits of its legal authority. Our task would be made easier if the young doctors, dentists, and nurses who come to us from their basic training had been better indoctrinated in the principles and practice of preventive medicine during their undergraduate days.

As the field of public health widens, the variety of special knowledge and skills increases. On-the-job training and inservice training are needed in every area, in order to keep staffs up-to-date. Too few state health agencies have developed the type of training program which will improve their chances for recruiting competent workers and increase the efficiency of existent staffs. The state health departments which have developed comprehensive training programs are benefiting to an extent far in excess of the expense and effort involved.

The total problem of professional education requires both study and action. A series of Acts of Congress, beginning in 1945, has given the Public Health Service an increasingly heavy responsibility and broad authority to augment medical research generally, and training in special fields. Our advisory councils, who must study and recommend the approval of grants to outside institutions, have felt the need of objective data as a basis for their policies and actions in this field.

About two weeks ago, the National Advisory Health Council recommended that the Public Health Service undertake a thorough study of its research and educational grants and fellowships programs, including the costs of medical education. "One of the chief purposes of this study," the Council reported, "is to determine whether present Public Health Service programs or other methods may be recommended for the improvement and extension of medical education."

By assembling data on the costs of teaching facilities in relation to the total costs of medical education, the Council hopes to be able to evaluate the effect of the grants programs on medical school finance and on medical education. The Council further recommended that a special committee be appointed to develop the study. We are hopeful that the study will provide a basis for similar analysis of other branches of professional education in which the Public Health Service has a specific interest.

The broad functions of the Public Health Service, obviously, give us an interest both in basic training of the major professional groups, and also in their graduate work. At times in the past, I believe that our colleagues, and even some of our own officers, have forgotten that when, in 1912, the 62nd Congress gave us our definitive title, the Public Health Service, it did not exclude—but specifically included—our medical care programs. There has never been a time in our 150 years of existence when the Service was not the major federal agency for civilian health. This was true when the Service was a handful of locally operated hospitals for sick and disabled seamen, as it is true today. The difference in functions is one of perspective, not of haphazard addition of responsibilities.

Our first hospitals are among the oldest general hospitals in the United States. The Boston Marine Hospital, for example, is the fourth oldest in the

country, preceded only by the Pennsylvania Hospital in Philadelphia, the New York Hospital (now Bellevue), and Charity Hospital in New Orleans.

Very early in its existence, the Marine Hospital Service had a close relationship with medical faculties and the training of physicians. As early as 1804, the Boston Marine Hospital became the first teaching hospital of Harvard Medical College, through the efforts of one of the giants of American medicine—Benjamin Waterhouse. Dr. Waterhouse was on the original faculty of the medical school, and served as physician-in-charge of the Marine Hospital for 4 years. He was among the first medical educators to realize the inadequacy of the didactic instruction and apprenticeship of those days. The Boston Marine Hospital was the scene of his experiments in applying new European methods of hospital administration and professional training. Waterhouse is also remembered as the physician who introduced vaccination in the United States.

I have dwelt upon some of these early activities because we sometimes overlook the close relation of the beginnings of preventive medicine and hospital care to public health. It is common to set the origin of the public health movement in the great sanitary reforms of the latter half of the 19th century. The importance of sanitation, and its place in the foundation of the public health structure, cannot be—and is not—disputed. In the light of modern knowledge and modern concepts, however, we are coming to see that "public health" is not and never has been a thing-in-itself, but a part of a larger whole: man's social effort for the conquest of disease and the attainment of health.

Such a concept includes the achievements of clinical medicine, the professional schools, the private hospitals, as well as the achievements of public agencies in the field of medical care. It includes the whole history of medical research in this country, a field in which state health agencies should be much more active. And, of course, the total concept of public health includes all those collective efforts by official and nonofficial agencies to apply preventive measures for the protection of all the people.

By some insight, conscious or dimly sensed, the people of the United States through their Congresses have maintained in the Public Health Service that unity of functions—research, clinical medicine, and public health administration—which constitutes the public health movement of today. There may have been times in our history when the Service has not been conspicuous for the excellence of its performance in all of these fields; but I think it is right to say, those times have been few.

Since 1939, the Public Health Service has been a constituent unit of the Federal Security Agency. That shift placed the Service where it could best grow and develop to fulfil its destiny; that is, it placed the major health agency in close administrative relation with the educational and public welfare programs of the government. The health policy of the United States Government, as represented by Congressional Acts and the work of the Public Health Service, the Children's Bureau, and related programs, has never been partisan, nor even bipartisan. It is non-partisan. We of the Public Health Service and our federal colleagues are going to do all in our power to keep it that way.

The Public Health Service is a public servant. Each member of our team is proud to name our calling. We take this role to mean that we do the chores assigned to us by the people of the United States. But it is no "hired man's" job. To us, it is a task calling for an incredible variety of skills, abilities, and knowledge; a task calling for

creative thinking of a high order. It calls also for leadership, rather than routine obedience. Unless we can bring these qualifications to the job of public servant, we cannot discharge its responsibility with the moral and intellectual integrity it demands. The job also offers limitless possibilities for satisfying work with colleagues in scores of professions, hundreds of institutions and health agencies. Collaboration in man's great quest for health is, to our way of thinking, the highest human indeavor.

We expect to go on serving in that capacity with the same good, self-imposed discipline and integrity which our professions and our predecessors in the Service have taught us. The Public Health Service has one sole interest: *to do* and *to be* only what is best for the health of the people. As in the past, we await their orders.

Canada Acknowledges A.P.H.A. Resolution on National Health Program

The following letter has been received from Paul Martin, Minister of National Health and Welfare of Canada in reference to Resolution 21 adopted by the Association and published in January *Journal.*

"I wish to express to you and to the members of the Governing Council of the American Public Health Association my thanks for the very encouraging resolution relating to our new National Health Programme which was adopted at the recent annual meeting in Boston.

"We are convinced, of course, that the programme is of great significance and promises possibilities for tremendous developments in the health field of this country. I believe we have an opportunity to do really helpful things for our people. Naturally that is my first concern. However in addition and possibly in the long run just as fruitful, there is a wonderful opportunity for new thinking, new projects, and significant developments in health work. Such possibilities naturally are most intriguing and challenging.

"It is in this latter connection that I wish to tell you how much we in this country value the very fine relationships which our health officers enjoy with those of the United States. This is true not only of individual workers, but, also of great voluntary organizations such as your Association and of government officials at all levels. The hospitable way in which we are always received in the United States and the generosity with which advice and information are always tendered is a matter of great pride and satisfaction to us. I know quite well that this spirit of coöperation and this helpful collaboration will contribute much to the maximum development of our new programme.

"Again may I express our gratitude for the resolution. I hope you will find it possible to convey this message to the members of the Council."